may be able to practise it yourself, even if you are only one of the laity. But, any way, we can put you in the way to obtain spiritual healing."

This is no fantastic interpretation of the aims of this guild, and I repeat that such societies can only retard that most desirable closer union of religion and medicine in a combined attempt to help the mental and physical health of mankind.—I am, etc.,

London, Sept. 19th. STANLEY BOUSFIELD.

"SPIRITUAL HEALING."

SIR,—I know of a case, the wife of a professional man, who suffered badly from hysteria associated with bronchial asthma. She attended several medical men, but the hysteria remained uncured until she was brought under the influence of a quack who assumed "spiritual healing." She recovered moral power, and her hysteria left her—the evil spirit was cast out, and she is regarded by all her friends as "cured."

There are still occasional troubles of a bronchial character, which show the organic changes in the lungs, such as are associated with chronic bronchitis, remain, as they necessarily must, uncured. It suffices for the "cure" that the hysteria has disappeared, and the woman is able to perform the ordinary duties of her position in life.

As long as the Rev. F. Boyd and his following are content to be correctly labelled as ministering to those who have lost their mental power, as evidenced by hysteria, and are careful to treat *patients* only, and not *diseases* of an organic character, it will not matter much.

If this be clearly stated the public will be in no danger from their interference, though I am inclined to think the correct diagnosis will be disputed, or, at any rate, objected to, by both the shepherd and his sheep.—I am, etc,

September 19th. J. W. T.

SHIP SURGEONS.

SIR,—A number of your correspondents seem to be unaware of the fact that for a few years past the chief steamship companies at Liverpool have had printed on the backs of tickets issued *to first-class passengers* a notice to the effect that the ship surgeon is entitled to charge reasonable fees for the treatment of such sick passengers. I take some credit for the adoption of this rule, and not a few surgeons have told me that it has greatly lessened their work as to the treatment of very trivial affections, while it has given them *the right* to ask for, and accept, fees. It is further provided by some of the steamship companies that a passenger has the right to appeal to the captain if the fees are thought to be excessive. I am told that on the Austrian Lloyd Company a similar notice is fixed in the saloon. I think one tourist steamship company in London has printed on each ticket a notice to the effect that the surgeon (who is not paid any salary by the company) is entitled to charge sick passengers the usual fees.

It is difficult to understand why the deans of the medical faculties do not "post" newly qualified doctors as to the conditions of sea life, and to advise them how to act. The ship surgeon is the only person on board a ship who remains at the salary he began upon—generally £10 per month—no matter how many years he serves. Whose fault is this? Only his own. I think I am right in stating that the Booth Steamship Company pay their surgeons up to £20 per month.

I have often thought it would be a very desirable plan to promote surgeons to the first-class ships as vacancies occur, and to give them an increase of salary each year. Some have suggested an annual bonus, but this is very nebulous, especially as many passengers may complain! It has also been suggested that sea-going doctors should have their own union in London, and that only and solely through this union should ship doctors be supplied. This is an idea worth thinking upon.

The class of men going to sea now is usually a good class, while the number of the sick public taking sea trips is increasing yearly.

Ship surgeons suffer from the same chronic complaints as do others of the medical calling in so far that they will neither organize, nor will they pay those who organize for them. Even the dock labourers and street sweepers have their organizations, and can bring influence to bear with the view of furthering their betterment. Ship surgeons also suffer like others of us in this respect, that they feel if one or two of them become "agitators," the other "deadheads" will jump at their places! Well, if this is an incurable social disease, let the ship surgeons suffer. Any body of men should receive what they ask for, even if this be the ignoring of their supposed sufferings. It is for them as a body, and *only* as a collective body, to draw up a reasonable proposal and to act upon it. This they have for at least thirty-five years refused to do. Their only idea is to go on growling—as they seem to prefer to do—and to be ignored. What do they want? To be mugwumps?—I am, etc.,

Liverpool, Sept. 18th. R. R. RENTOUL.

"KANGRI CANCER": A PHYSIOLOGICAL ASPECT.

SIR,—The original articles on the subject of cancer which appear in the BRITISH MEDICAL JOURNAL of September 3rd, along with your complementary extract from the third scientific report on the investigations of the Imperial Cancer Research, while affording instructive reading, call for a few remarks by a former colleague of Dr. Neve, twelve years of whose early professional career were spent among the people of Kashmir (1884–95). The points I desire to submit are: The well-known association of cancer incidence with riverine districts and alluvial soils, as shown among the dwellers of the Vale of Kashmir, compared with those inhabiting the surrounding mountainous regions—namely, Ladakh and Iskardu to the north and Poonch and Kishtwar to the south. It is true that the mountaineers, being more hardy, resort less to this means of warmth during the winter months, but the extreme rarity of the disease among them cannot thus be accounted for, though all these tribes are equally verminiferous in their apparel. The kangri is only worn during the winter months, from October till April; during the remaining six months there is opportunity for recovery from its irritative effects. With the other well-known chemical and thermic irritants, as the chewing of betel nut and lime, or the clay pipe smoking, the effect is more continuous throughout the years. May this account for the lesser "malignancy" of the former type?

In regard to the clinical pathology, Dr. Neve states that, "Glands are slow to show signs of infection." There does not seem to be any distinction drawn between the physiologically involved glands which hypertrophy in functioning and those that have degenerated and become subsequently infected.

The detection of involved glands merely by palpation, it will be admitted, is no simple matter, and one that is open to serious fallacy. Those that are hypertrophied are not necessarily infected.

Mr. Barrett Lockwood, alluding to the changes in the axillary glands in a case of mammary carcinoma extirpated by him, says:[1]

> The axillary lymphatic glands were sent for examination. Mr. Ernest Shaw, whose histological skill is acknowledged, reported that *the large glands did not contain cancer, but that some minute ones did* (italics mine). This, too, Mr. Shaw tells me, is an ordinary experience.

I beg to submit that these "minute ones" were supernumerary ones in a state of evolution that had come into being to meet the requirements, just as they do around the mammary gland during the period of lactation, to meet the mouth infection of the milk ducts by the infant, a fact first observed by Stiles. They became infected, being in a rudimentary and immature state, *and these, owing to their minuteness*, often escape inclusion in the radical operation.

The inguinal lymphatics of the Kashmiri after middle life are, in the great majority, in an unhealthy state, owing to the fact that probably no race under the sun is more afflicted with venereal disease and its sequelae.

Another reason for the apparent non-malignancy and late involvement of the glands, apart from their remoteness from the umbilical region, might be the compensatory functioning of the large prickle cells of the rete Malpighi, which are lymphoid in character, and would react outside a certain radius of the areas denervated by the constant heat.

The acquired denervations produced by mechanical, chemical, and thermic agents, though greater in degree,

[1] BRITISH MEDICAL JOURNAL, January 27th, 1906.

seem to be analogous to the physiological trophic degeneration of the sexual organs and their adnexae at the "change of life."

The denervations induced by the molecular action of the *x* rays is markedly different from that produced by the well-known agents enumerated. By this action of radio-active agents it is possible to induce step by step cellular changes which have all the clinical and histological features of epithelioma in the shortest time, at any age, on any *normal area* of the body, including the bones, while it is much more difficult, if even possible, to induce similar changes on *abnormal areas*, such as scar tissue or previously denervated areas from other causes, by this means. The effect is the very opposite—namely, a re-innervation of such areas. I have drawn attention to these effects elsewhere recently.[2]

Again, it has been shown that in ordinary cancerous processes the histological changes are more conspicuously retrograde than recuperative;[3] in the *x*-ray changes they are conspicuously recuperative. Lymphatic gland involvement is almost unknown, and, where it has been found, was probably the result of secondary microbic infection intercurrently acquired.

I have not seen Dr. Haarland's view as to how cancer develops in mice in association with continuous or intermittent efforts at repair and regeneration, but Dr. Clowes, of the New York State Cancer Laboratory, stated that:[4] "The tendency (is) often noticed in tumours to remain stationary after fairly rapid development, and then subsequently either to grow rapidly or retrogress. In this connexion it must be noted that *x* rays produce a much more marked effect at this stage, at which apparently the disease has quite overcome the natural immunity of the mouse."

Messrs. Farmer, Moore, and Walker, of the Liverpool Cancer Research Laboratories, have shown that by subjecting Jensen tumour tissue to the prolonged freezing action of liquid air its "malignancy" or capacity for successful implantation was greatly increased, and I cannot conceive of any mammalian tissue cells surviving such an ordeal, though the more lowly minute microbic forms evidently do so.—I am, etc.,

London, W., Sept. 4th. H. D. MCCULLOCH.

A CAUSE OF DEATH AFTER OPERATION FOR APPENDICITIS.

SIR,—In your issue of August 27th there was a short paper by Mr. Herbert Brown, of Ipswich, on this subject, which appealed to me very strongly. My experience corroborates every word of Mr. Brown's paper, and I am sure if the axioms as to treatment at the end of his article were followed out many more lives would be saved by operation. Children cannot stand a severe operation, and it is much better to leave the appendix, as a general rule, after opening and draining the abscess cavity. In a similar case to the one described by Mr. Brown, a little girl of 5 years who died sixteen hours after operation, I put death down to shock from the manipulation necessary in order to remove the appendix, but whether due to shock or to the sudden deluging of the system with toxins, as Mr. Brown thinks, the moral is the same—the less manipulation that the patient has to undergo the better, especially if the patient is a child. General practice teaches one that the appendix may be safely left behind in abscess cases as it rarely gives rise to any trouble afterwards.

Of course, besides the danger of death in twenty-four hours, there is always the risk of causing a localized abscess to become a spreading peritonitis by insufficient packing off of the peritoneal cavity, and I am afraid I have seen cases lost from this cause; these patients succumb on the third and fourth day generally, and are quite distinct from the cases quoted by Mr. Brown. This danger is another reason for delaying operation to the end of the first week or even ten days from the commencement of symptoms as advised by Mr. Brown, as by that time adhesions are stronger and in many cases the anterior abdominal wall is involved in the abscess cavity, and the general peritoneal cavity is not opened at all.

Operating during the first twenty-four hours is a counsel of perfection that is very rarely feasible in general practice, the two great difficulties being that the friends delay in sending for a doctor sometimes in the worst cases, and, secondly, the patient withholds consent at first.

Another reason for not being in a hurry to operate in acute cases first seen after twenty-four hours from commencement of the attack is that it is wonderful how often cases that one feels certain must go on to abscess will settle down again; rigidity of the abdominal wall and palpable masses disappear as if by magic, so that the case eventually comes to be treated by an interval operation.

For these reasons, in addition to those given by Mr. Brown, I heartily commend his axioms as to treatment as stated at the end of his article.—I am, etc.,

W. A. REES, M.D Lond., F.R.C.S.Eng.

Swanage, Sept. 2nd.

SIR,—Mr. C. A. Morton disagrees with my theory, on grounds which appear to me to be somewhat trivial and partly founded on a misconception of my meaning.

Of course, every one knows that a septicaemia is fatal not because of the "mechanical effect of the organism in blocking minute vessels," but because of the chemical effect of the toxins elaborated by the organism.

I understand by a *septicaemia* a *toxaemia* produced by organisms multiplying in the blood or lymph stream.

Needless to say, I did not suggest any such mechanical theory to explain these cases.

My reasons for attributing the fatal issue to a septicaemia rather than a toxaemia alone were, first, that I did not think a sufficiently large dose of toxin would be absorbed from such a small area in the short time occupied by the operation, and secondly, because there seemed to be a definite incubation period of from six to twelve hours, during which the patients appeared to be progressing normally; the serious symptoms often came on almost suddenly. I have seen an acute streptococcic infection with pus formation manifest itself within six hours of an operation. I must confess, however, that I have no proof of this theory, as I have not attempted to obtain a culture from the patient's blood.

But the question of toxaemia or septicaemia is of minor importance, and we are both agreed as to the danger of removing the layer of lymph. Then Mr. Morton refers to two cases in which a gangrenous appendix was removed, both of which died with the symptoms which I have described. Of course the presence of pus is not necessary; it is not the pus, but the organisms and toxin which are the source of danger, and a gangrenous appendix is a hotbed of organisms. In fact, a case of this kind would be more dangerous, as there is less likelihood of the presence of a well-defined layer of lymph surrounding the focus of infection.

He goes on to quote four cases in which the symptoms of appendicitis had been present for a week or more before operation. These cases only came under his care at the time of operation; but, even if the symptoms referred to the appendix had been present for more than a week, it by no means follows that an abscess had existed for that period.

My plea is for delay in operating unless the case is seen in the first twenty-four hours, or there is other indication such as commencing general infection of the peritoneum, etc. Of course this applies to cases which can be kept under close observation, and the surgeon should be ready to operate at any time when it appears to him advisable. In these days of hospitals and surgical homes such a course is generally quite feasible.

Sir Frederick Treves years ago advocated delay; he considered an operation during the first week especially dangerous, and I think later experience has justified this opinion.—I am, etc.,

Ipswich, Sept. 4th. HERBERT H. BROWN.

PORTRAITS ILLUSTRATING "SPOTTED FEVER."

SIR,—In the Clinical Museum (The Polyclinic) we have no single representation of the eruption which sometimes attends the form of cerebro-spinal meningitis which has been by some named "spotted fever." If any of your readers can assist me to obtain a drawing which we could copy I shall be much obliged. It will be still more satisfactory if we can borrow several. They will be well cared for and duly returned.—I am, etc.,

London, W.C., Sept. 20th. JONATHAN HUTCHINSON.

[2] Dr. McCulloch, ibid., August 27th, 1910, p. 524.
[3] Dr. James Metcalfe, ibid., August 27th, 1910, p. 542. Ibid., December 1st, 1906, p. 1553.